Indiana State Department of Health

|                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X3) DATE SURVEY<br>COMPLETED                  |  |
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|                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | A. BOILDING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | С                                              |  |
| 003350                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 07/01/2013                                     |  |
| NAME OF PROVIDER OR SUPPLIER S                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                 | STREET ADD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | EET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                |  |
| I CT VINCENT CETON CDECIALTY LICCUITAL INDIANA I                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)                                        |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (EACH CORRECTIVE ACTION SHOULD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | BE COMPLETE                                    |  |
| S 000 INITIAL COMMENTS                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | S 000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                |  |
| This visit was for the investigation of a licensure complaint.                                                                                                                   |                                                                                                                                                                                                                                                                                                                                 | sure                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                |  |
| Survey Type: Licensure complaint IN00130480                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                |  |
| evidence.                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                |  |
| Date of Survey: 07-01-13                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                |  |
| Facility number: 003350                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                |  |
| Surveyors: John Lee, R.N. Public Health Nurse Surveyor                                                                                                                           |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                |  |
| St Vincent Seton Specialty Hospital, Indianapolis is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-9, Radiologic services, Hospital Licensure Rules. |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                |  |
| QA: claughlin 07/12/                                                                                                                                                             | 13                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                |  |
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|                                                                                                                                                                                  | SUMMARY ST (EACH DEFICIENCE REGULATORY OR I  INITIAL COMMENTS  This visit was for the complaint.  Survey Type: Licensus IN00° Unsubstante vidence.  Date of Survey: 07-0  Facility number: 0033  Surveyors: John Lee Public Holding St Vincent Seton Species in compliance with control and 410 IAC services, Hospital Licenses | ODUIDER OR SUPPLIER  NT SETON SPECIALTY HOSPITAL, INDIANA  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUR REGULATORY OR LSC IDENTIFYING INFORMATION INITIAL COMMENTS  This visit was for the investigation of a licens complaint.  Survey Type: Licensure complaint IN00130480  Unsubstantiated, lack of sufficient evidence.  Date of Survey: 07-01-13  Facility number: 003350  Surveyors: John Lee, R.N.  Public Health Nurse Surveyor  St Vincent Seton Specialty Hospital, Indiana is in compliance with 410 IAC 15-1.5-2, Infect control and 410 IAC 15-1.5-9, Radiologic | OUTS THE CORRECTION STREET ADD STREET ADD SOS TOWN INDIANAPO  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  This visit was for the investigation of a licensure complaint.  Survey Type: Licensure complaint IN00130480  Unsubstantiated, lack of sufficient evidence.  Date of Survey: 07-01-13  Facility number: 003350  Surveyors: John Lee, R.N.  Public Health Nurse Surveyor  St Vincent Seton Specialty Hospital, Indianapolis is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-9, Radiologic services, Hospital Licensure Rules. | DENTIFICATION NUMBER:  A. BUILDING:  DOUBT OR SUPPLIER  NT SETON SPECIALTY HOSPITAL, INDIANA  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for the investigation of a licensure complaint.  Survey Type: Licensure complaint IN00130480 Unsubstantiated, lack of sufficient evidence.  Date of Survey: 07-01-13  Facility number: 003350  Surveyors: John Lee, R.N. Public Health Nurse Surveyor  St Vincent Seton Specialty Hospital, Indianapolis is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-9, Radiologic services, Hospital Licensure Rules. | DEFICIENCY DISTRIBUTION NUMBER:    A BUILDING: |  |

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE